

*First Report
of the
Psychiatric
Patient Advocate Office*

86-02317/

FIRST REPORT

of the

Psychiatric

Patient Advocate Office



SWADRON, BROWN & ASSOCIATES

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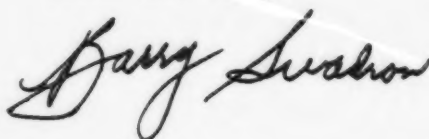
The Honourable Murray Elston
Minister of Health
Province of Ontario
10th Floor
Hepburn Block
Queen's Park
Toronto, Ontario
M7A 1R3

Dear Mr. Minister:

It is with pleasure that I submit on behalf of the Advisory Committee the First Annual Report of the Psychiatric Patient Advocate Office.

The members of the Advisory Committee for the Psychiatric Patient Advocate Office wish to take this opportunity to express our continuing interest and commitment to the rights of psychiatrically disabled people.

Yours very truly,



Barry B. Swadron, Q.C.
Chairperson,
Advisory Committee
Psychiatric Patient Advocate Office

BBS:sb

BARRY B. SWADRON, Q.C., LL.B., LL.M.
(ALSO OF THE BAR OF PRINCE EDWARD ISLAND)

ROBERT P. KOTZER, LL.B.

ARTHUR C. BROWN, B.A., LL.B.

MARION E. LANE, LL.B., LL.M.
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Psychiatric Patient Advocate Office

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2nd floor, 890 Bay Street, Toronto M5S 1Z8 / Telephone 927-1575

Tyrone S. Turner, M.D.
Provincial Co-ordinator

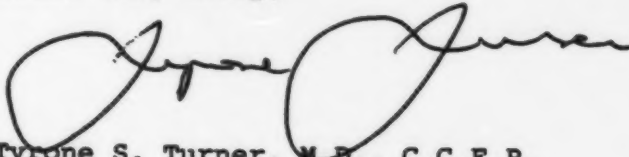
Dr. Allan Dyer
Deputy Minister of Health
10th Floor
Hepburn Block
Queen's Park, Toronto
M7A 1R3

Dear Dr. Dyer,

Pursuant to my mandate, I submit the first Annual Report of the Psychiatric Patient Advocate Office. It has given me great personal and professional pleasure to have served as the Provincial Co-ordinator to this new program, in its fledgling year.

I look forward to discussing its contents with you, and other interested members of government and the public.

Yours very truly,

A handwritten signature in black ink, appearing to read 'Tyrone S. Turner', with a large, stylized loop at the end.

Tyrone S. Turner, M.D., C.C.F.P.
Provincial Co-ordinator

TST/eef



DEDICATION

To the late Kit Holdsworth, the
first Patient Advocate at
Hamilton Psychiatric Hospital.

She left behind a new and vital
contribution.

**Psychiatric
Patient Advocate
Advisory Committee**

1983-84

Barry Swadron, Q.C., LL.B, LL.M.,
Chairman

Alex Isbister, M.S.W.
Ruth Gallop, R.N., M.Sc.N.
Pat Capponi
Mel Bornstein
Bernard Dickens, LL.B., LL.M.,
Ph.D., LL.D.

Linda Beals, B. Mgt.
Winnie Norton, R.N., H.O.M.

* Don Wasylenki, B.A., M.D., M.Sc,
F.R.C.P.(C)

**Psychiatric
Patient Advocate
Office**

1983-84

Tyrone Turner, M.D., C.C.F.P.,
Provincial Co-ordinator

Susan Atkinson, Executive
Assistant
David Solberg, LL.B., Legal
Counsel
Helen Schneider, Secretary

Hospital Served

Brockville Psychiatric Hospital
Hamilton Psychiatric Hospital

Kingston Psychiatric Hospital
Lakehead Psychiatric Hospital
London Psychiatric Hospital
North Bay Psychiatric Hospital
Penetanguishene Mental Health
Centre

Queen Street Mental Health
Centre

St. Thomas Psychiatric Hospital
Whitby Psychiatric Hospital

Elaine Atchison, R.N.
**Karen (Kit) Holdsworth, R.N.,
B.S.W.
Burry Wiseman, B.A., M.Div.
Jorma Halonen, B.A.
Donna Hall
Valrita Fournier, B.A.
Michael Mullan, M.S.W.

Mary Frances Madill, PhD.,
LL.B.
David Giuffrida, LL.B.
Doris Baker, M.S.W.
Catherine Burns, LL.B.

* Resigned

** Deceased, November 28, 1984



EXECUTIVE SUMMARY

The Psychiatric Patient Advocate Office was established in 1981 with a Provincial Co-ordinator, Dr. Tyrone Turner, appointed in November, 1982. By May, 1983, eleven Advocates were working in all ten Provincial Psychiatric Hospitals advising patients and staff of patients' rights and acting on the instructions of patients to resolve various concerns, queries and complaints.

The specific hospitals served are: Brockville Psychiatric Hospital, Kingston Psychiatric Hospital, Whitby Psychiatric Hospital, Queen Street Mental Health Centre, Hamilton Psychiatric Hospital, London Psychiatric Hospital, St. Thomas Psychiatric Hospital, Lakehead Psychiatric Hospital, North Bay Psychiatric Hospital, and the Mental Health Centre at Penetanguishene.

During their first year of operation, the Advocates served more than 2,200 patients out of a total of 12,700 admitted over one year to the Provincial Psychiatric Hospitals, occupying, on any day, approximately 4,000 beds.

One task given to the office when it was established was to evaluate the effectiveness and range of the program so it could evolve in ways that would ensure compliance within the health care system with the equality provision of the Charter of Rights and Freedoms which came into effect April 17, 1985.

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This report is based on an analysis of program operation during the 1983-84 fiscal year.



FOREWORD

The establishment of the Psychiatric Patient Advocate Office was partly the result of heated debate within the mental health care system, in 1981, over the issue of whether or not two final sections of the Mental Health Act of 1978 should be proclaimed.

These were Sections 66 and 67.

Section 66 of the Act required that when an attending physician completes a Certificate of Involuntary Admission or Renewal, the physician must give notice in writing of the fact to the patient and to the Area Director of Legal Aid. Further, this section entitled the patient to a hearing by the Regional Review Board. The Regional Review Board is an administrative tribunal established under the Mental Health Act.

The provisions of Section 67 of the Act were intended to replace the informal hearing procedures of the Regional Review Boards with more formal, court-style proceedings which required traditional tests of natural justice.

Many consumers and providers within the mental health care system agreed with the spirit of those two sections.

But following extensive consultations with a number of groups, the Minister of Health felt that an incremental, or phased-in, approach might better enable the system to adjust to this new procedure.

At that time, the majority of medical professionals felt that the approach to mental illness should be primarily medical, not legal or custodial. They said that the objective should be health and healing, not "rights" and court hearings.

At the same time, there were lawyers and consumer rights groups who felt equally strongly that the system of involuntary admission for non-criminal patients into the mental health care system required the adoption of certain legal procedures and safeguards against abuse.

Adding to the weight of the proclamation arguments put forward was the fact that in April of 1985 a section of the Charter of Rights and Freedoms of the new Canadian Constitution would take effect, dramatically expanding the entire system of human rights entitlements for the psychiatrically disabled and others.

An integral part of the new Constitution is the entrenchment of a Charter of Rights and Freedoms whereunder the State guarantees individual self-determination to its people. A principal guarantee of the Charter is, for example, contained in Section 7, which assures Canadians the right to life, liberty and security of the person.

On April 17, 1985, Section 15 of the Charter extended these protections to all people, regardless of sex, age, religion, national or ethnic origin, colour, race, and physical or mental disability.

In the mental health care system, the weight of these new provisions in the Charter is expected to result in pressure for equalization of safeguards over liberty, the right to control one's body, and matters related to psychiatric commitment and to the right to consent to treatment.

Related matters, such as safeguards over seclusion, restraint, communications, privileges and restrictions, will also be subject to judicial review under the new law.

Therefore within this atmosphere of increasing attention to human rights, and with the potential impact of the

Charter, the need for a pragmatic program to introduce the Charter's protections into the mental health care system was becoming a major priority within the Ministry of Health by the spring of 1982.

But experience had already shown that existing civil and human rights only penetrated psychiatric facilities with limited depth.

This lack of penetration may have been caused by a number of factors, namely: the patient's disability; the regressive effects of hospitalization on individuals; the marked power imbalance between the patient and the treating professional; and, the health care system's traditional focus on health care, rather than on rights protection.

However, general public dissatisfaction with the mental health system was further aroused by three highly publicized deaths in 1980 and 1982 in Ontario's psychiatric hospitals, and the subsequent Coroners' Inquests mobilized consumers, volunteer organizations, and human rights groups to form a high-profile coalition which lobbied strenuously for an external legal advocacy program for institutionalized psychiatric patients.

In early 1982, despite Government spending restraints, the Minister of Health responded to these concerns with increased spending on a package of reforms in the mental health care system, featuring Community Advisory Boards for Provincial Psychiatric Hospitals; new community mental health care programs; a reorganization of mental health administration within the Ministry; and a new Patient Advocacy Program.

The advocacy program was to be Canada's first province-wide system of human rights advocacy for psychiatric patients and was well received by patient rights groups and by the public.

This new patient advocacy program extended human rights protection to all in-patients in Provincial Psychiatric Hospitals, or to approximately 12,700 of the more than 53,000 people who were admitted to psychiatric facilities in the province of Ontario during the period of April, 1983 to March, 1984. At any one time, in Ontario, a total of approximately 7,000 beds are occupied by people requiring some type of psychiatric care. Patient Advocates currently provide services to 57% of the people in these 7,000 beds.

In order to enable the newly established Psychiatric Patient Advocate Office to meet the changing conditions and the needs of these people, the mandate of the program was a general one.

Basically, the Patient Advocates were to:

- * advance the human rights of psychiatric patients in all Provincial Psychiatric Hospitals;
- * inform the patient, family, hospital staff and the community about patients' human and legal rights;
- * assist, facilitate and help resolve the complaints made by psychiatric patients;
- * assist patients with their complaints and provide an avenue for solutions by negotiation according to the patients' instructions;
- * refer patients, when necessary, to outside community advocacy resources, such as community organizations, lawyers, or physicians who may offer a second psychiatric opinion; and,

- * to evaluate the program in order to recommend changes to the system so that it could evolve in ways that would ensure compliance with the Charter by the spring of 1985.

Patient Advocates were initially placed within a reporting relationship to the Ministry of Health so that they could begin their advocacy work from "inside" the system with the full support of both the Minister and Deputy Minister of Health.

However, a critical feature of the program was that the Advocates were to be independent of hospitals where they worked, and report directly to the Provincial Co-ordinator for the Psychiatric Patient Advocate Office, who in turn reported directly to the Deputy Minister of Health.

And, as an additional buffer to ensure the program's independence, the Minister also established the Psychiatric Patient Advocate Office Advisory Committee, comprising mental health consumers and providers, as well as lay and legally trained advocates.

This Committee was charged with several responsibilities: advise the Provincial Co-ordinator; make regular reports to the Minister and the Deputy on the progress of the program; and

make recommendations on appropriate changes to the program's design and concept.

One of the major initial tasks given to the program was to work within the system to collect information about rights violations and rights protection and to assess whether or not Section 66 and 67 of the Mental Health Act should be proclaimed.

Since these sections were considered to be so controversial by some staff members of psychiatric hospitals, the Patient Advocates initially spent time gathering data; explaining human rights issues; and explaining the impact that the Charter of Rights and Freedoms would eventually have on the system after the spring of 1985.

Following a suitable assessment of the data, some of which is presented in the Tables on pages 21-25, the Psychiatric Patient Advocate Office recommended that the rights protection contained in Sections 66 and 67 be proclaimed as a further step in the evolutionary process towards eventual compliance with the Charter of Rights and Freedoms.

On March 1, 1984, the Minister of Health implemented our recommendation and these sections were proclaimed in law.

As this Annual Report demonstrates, we have come a long way in just eleven months. The Advocates have made a significant impact on the operations of the Provincial Psychiatric Hospitals and on the level of awareness of patients' rights among both staff and patients.

As this first Annual Report of the Psychiatric Patient Advocate Office demonstrates, we still have a long way to go towards developing a more dignified and legally acceptable approach to the treatment of the psychiatrically disabled throughout the mental health care system.

A final aspect of the design of the Psychiatric Patient Advocate Office is an external review under the direction of an independent Steering Committee.

Ontario has Canada's first province-wide patients' rights system, and we are entitled to be proud of it. But, if our pride turns into complacency, we run the risk of losing ground in the movement toward advancing the status of psychiatrically disabled people.

The members of the Advisory Committee, all of whom are volunteers, have provided the Advocates and the Ministry with very

helpful advice and guidance over the past eleven months. On behalf of all the Patient Advocates throughout the province, I thank the Advisory Committee members for their invaluable assistance. In addition, I wish to thank the hundreds of mental health care consumers, providers and advocates who have provided often unwavering support, in both spirit and action.

Tyrone S. Turner, M.D., C.C.F.P.
Provincial Co-ordinator
Psychiatric Patient Advocate Office



OVERVIEW

The Psychiatric Patient Advocate Office has reached out to patients in Ontario's 10 psychiatric hospitals.

No doubt many improvements can be made to elevate services for the psychiatrically disabled to more humane, appropriate, and legally acceptable standards. After our first year, it is also certain that patient advocates can play a key role in directing and pressing for such improvements within the mental health care system.

It is estimated that, in any one year, eight per cent or more of the residents of Ontario receive medical services for psychiatric diagnoses. This is equal to the proportion of our population who receive non-psychiatric medical services.

The 'baby boom' generation is now 25 to 45 years old, the age category which makes the heaviest use of psychiatric facilities; the general population is aging, a fact which has important consequences for psychogeriatric services. Estimates indicate between one in four and one in seven persons seeks assistance for a mental health problem some time during his or her life.

Public attitudes toward mental disorders and the mental health care system have changed. We are no longer prepared to simply cast away those who are suffering from mental illness. Therefore, the quality of service must also change and continually improve if public opinion and growing consumer needs are to be satisfied.

The public and media have become painfully aware in the past few years that too often patients are being returned to the community without enough support to meet their basic housing, health and social needs. Society now realizes we cannot release psychiatric patients from hospitals on medication alone. They need more.

The media has reported cases showing current practices of incarceration of the mentally ill can be unjust and that existing standards of treatments are sometimes inadequate, even harmful. These cases include that of a New Brunswick man who spent 16 years in mental institutions after being declared unfit to stand trial for an attempted purse snatching when he was 19. They include a Toronto man who died after receiving exceptionally

large doses of drugs in a psychiatric facility.

Problems faced by patients within mental health facilities are public knowledge. Public scrutiny and growing understanding of problems in the mental health care system have engendered poor staff morale in these institutions.

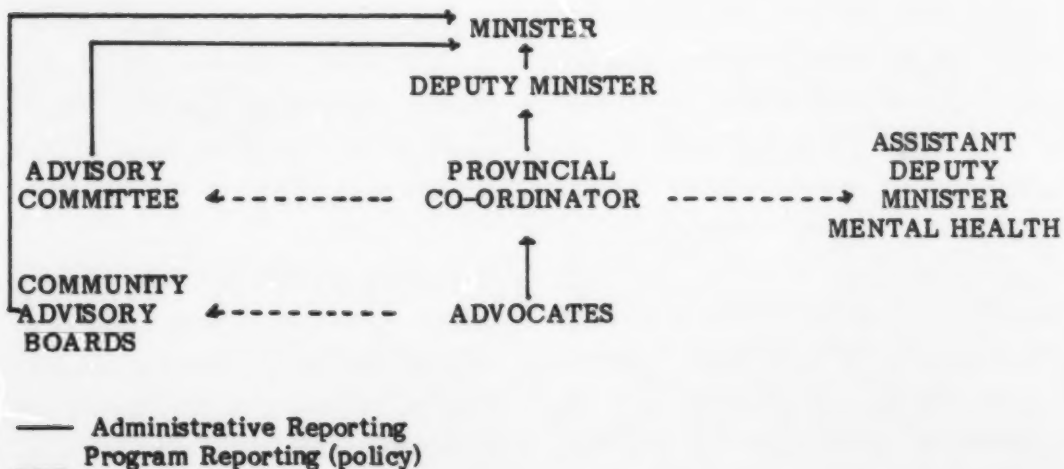
The Psychiatric Patient Advocate Office was established by the provincial Ministry of Health as part of a package of reforms early in 1981.

In November, 1982, Dr. Tyrone Turner was appointed by the Minister as

Provincial Co-ordinator in charge of the Advocacy Office. By May, 1983, eleven advocates had been hired from among more than 900 applicants. All eleven had some experience working in psychiatric institutions or with psychiatric patients.

Dr. Turner was also given the job of designing the advocacy program which determined the actual work carried out by the new advocates in the ten Provincial Psychiatric Hospitals.

The following diagram depicts the organizational and reporting relationships and structure of the Psychiatric Patient Advocate Office:



The main duties of Patient Advocates were to investigate concerns, inquiries and complaints, to link patients with legal counsel or community resources and to recommend to the ministry ways to improve mental health care.

The advocacy office was modelled on a general design which permitted

scope for the on-going development of policies and structural improvements. We think the built-in flexibility of the office has been of benefit because it has permitted us to evolve and plan through concrete experience. We have learned and have built the foundations of this office from our experience at "the ward level."

The program is mainly reactive. We tell hospital patients and staff about our duties through posters, brochures and word of mouth and we accept referrals from family, friends, staff and other patients. We take no action without instruction from the client/patient. However, this precludes serving those patients such as psycho-geriatrics, who are not mobile and cannot come to the advocate as easily as other patients.

This means most of our current activities reflect the concerns of hospital in-patients who have come forward with complaints and have given us instructions.

We have been encouraging local resolutions to concerns by talking with and negotiating between hospital staff and patients. As we gain experience and as our program matures, we see broader issues becoming more important.

FIRST STEPS:

In each hospital, a Patient Advocate and a secretary staff the local advocacy office and report directly to the Provincial Coordinator. They function as independent agents in each hospital.

The advocates were given, under Section 5 of the Mental Health Act,

complete access to wards, patients and documents. However, the program was not given any enforcement procedures or powers which would make it legally effective in its own right. From the outset, it was apparent that our program's success would depend entirely on the extent to which there was voluntary respect for and cooperation with advocates by the hospital staff members and administrators.

During our first year of operation, there have been problems. Some staff in hospitals viewed the introduction of this program as potentially threatening. However, others welcomed us along with the other new initiatives instituted by the government.

Within the institutions, staff provided advocates with many opportunities to describe the program, to explain patient rights and to demonstrate the Patient Advocate Office as an agent of appropriate change.

While there was some initial confrontation and reluctance to accept the program, hospital staff co-operation has grown and caused patient advocacy to be more effective. For instance, treatment staff often refer patients to Advocates when there is a concern about rights and entitlements.

THE ADVOCATES:

Between November, 1982, and May, 1983, eleven Patient Advocates were chosen from 900 applicants. Each Advocate was posted in one of the ten Provincial Psychiatric Hospitals throughout Ontario (with 2 Advocates at Queen Street Mental Health Centre) with a mandate to speak for the in-patients of these institutions and to learn from them. Patient Advocates are well qualified people.

They include a Ph.D. clinical psychologist who is also a lawyer; two registered psychiatric nurses, one of whom has social work qualifications and the other a former head nurse in a Provincial Psychiatric Hospital; two social workers; two former investigators with the Ontario Ombudsman's office; a former labour negotiator; a former public relations officer with awards for human rights work; a lawyer with extensive experience in counselling psychiatric patients; and a trained pastoral counsellor.

All Advocates received special training before they began work. This included sessions provided by lawyers, consumer advocates, psychiatrists from the Clarke Institute of Psychiatry, as well as other medical and legal experts. Ongoing training and staff development programs continue.

The advocates combine sound knowledge of psychiatric disabilities with skills in negotiation. They have extensive knowledge of human rights safeguards combined with legal and para-legal expertise. They are encouraged to develop strategies for local in-hospital issues. They also propose and discuss strategies at the central level which, when implemented, can lead to broad change across the system within all institutions in the province.

CASE STUDIES

INSTITUTIONALIZATION - THE REALITY:

Ontario's ten Psychiatric Hospitals treated and discharged approximately 12,700 patients during our program's first year. Advocates acted for over 2,200 clients during this time and resolved many problems.

Some consumers are chronically disabled, while others are affected only temporarily, often by typically modern maladies arising from stress. Psychiatric patients must confront adjustments to the institutional setting itself, in addition to the realities of their initial psychological state.

Typically, a patient must adapt to real loss of control and changes in the routines of daily life. The patient, too, must yield the balance of power and is restricted in the wishes and complaints which may be voiced.

The following three case studies show the range and complexity of human problems facing our clients.

1. Loss of Control:

Many patients can be described as

'powerless'. On the basis of a psychiatric opinion, a person can be taken away from his or her home, family or work. He or she can be deprived of control over finances, be unable to marry, divorce, enjoy the custody of children, enter into a contract, drive a car, or vote.

A 31-year-old divorced woman was admitted to a Provincial Psychiatric Hospital in an acute schizophrenic state. Psychoactive medication had to be withheld from her until the birth of her infant four months later.

The mother gave birth. The day after she began her required medication she appeared in Provincial Court (Family Division). The woman was required to give evidence. She had no lawyer and there had been no legal representation for the child.

Her child was made a Crown Ward on a first application by authorities that the child be taken away from the woman. Later the woman could not recall being in court and was not aware her child had been taken from her permanently.

By the time the Patient Advocate became aware of the situation, the

child had been placed for adoption. The Advocate helped to obtain a lawyer on a legal aid certificate and, a few months later, the Crown Wardship was overturned.

2. Daily Living:

A person may be detained in a hospital and not told why, and may be required, or forced to take large doses of powerful medication and not told what it is or what its effects may be.

Once hospitalized, the patient is required and sometimes coerced to demonstrate behaviour patterns which conform not only to the majority's concept of 'mental health' or 'norms' but to satisfy the need for institutional order.

A patient ceases to make basic decisions about life: living by the rules that tell when to get up, when to eat, what to wear, which visitors to see, when to use the telephone and how much of his own money to spend. The patient may or may not be 'allowed' out of his room, off the ward or into the community.

A man spent almost 10 years in a maximum-security hospital.

He had been confined under a Lieutenant Governor's Warrant after

committing robbery and assault.

A physician brought the case to the attention of the Patient Advocate who found the original offence had involved a minor pickpocket incident and a fight with a drinking buddy. A plea of guilty at the time would have netted the man, even in the worst case, a jail sentence of less than two years.

During his 10 years in hospital, the man had no record of violent behaviour and, although he had walked away from several hospitals, he had always turned himself in later. His primary problem was alcohol.

At first, the Advocate found the man to be apathetic. There were questions about his past diagnoses and treatment. These were brought to the attention of the attending physician.

The Advocate helped to obtain a lawyer for the man and the attending physician took the patient off the medication. The patient became more alert and interested in his problems.

3. Balance of Power - Objections and Complaints:

The institution has the power to enforce its decisions. Often patients do not know they too have rights.

In the fall of 1983, a limited survey was conducted of in-patients at one of the Provincial Psychiatric hospitals. It showed that of the patients surveyed 50% were unaware of their basic right to an external appeal of their commitment certificates.

A complaint, a wish, a preference expressed by a patient can be taken by some staff as a sign of psychopathology. Resist hospitalization and you may be seen as 'denying or lacking insight'. Resist treatment and you may become 'a help-rejector' or 'an attention seeker'.

Patient Advocates have found, among patients, anxiety and fear, partly caused by the lack of choice for committed patients. They have found reluctance by patients to express wishes or to ask for rights lest their treatment become more coercive.

A 21 year old single male was referred to the out-patient department of one of the Psychiatric Hospitals by a psychologist for psychiatric assessment and possible admission.

He had a history of alcohol and drug abuse. He said he voluntarily came to the hospital on the suggestion of a relative for a "neurological consultation". He agreed to be admitted. But following one night in

the hospital he changed his mind and wanted to leave.

At that time his Doctor decided to certify him on a Form 3 which stated that he was a danger to himself under the category of "imminent and serious physical impairment of the person". The observations on the form stated "the patient is very paranoid, thinking that people are out to get him especially if he is asleep. He thinks that he will be sexually assaulted".

The patient was certified involuntary for two weeks.

The physician was so certain that this patient needed treatment that he requested an order for treatment from the Review Board. The treatment order was not obtained because the physician was unable to get a second psychiatrist to agree to the need for the order.

The Patient Advocate was called in and requested by the client to assist him in going to the Review Board and also in obtaining a lawyer. Within ten days he was heard by the Regional Review Board. They decided to revoke the Certificate of Involuntary Commitment.

The injustice in this case stems directly from the inappropriateness of

the Form 3 and also from the fact that an investigation of the facts revealed that the client had recently left a motorcycle club in which he had

some bad experiences—notably he was sexually abused while under the influence of drugs.

PATIENTS' RIGHTS ANALYSED

The Psychiatric Patient Advocate Office is Canada's first province-wide system; therefore, we have set ground rules and definitions. One key area has been identifying and defining patients' rights.

We recognized early if we were to define psychiatric patient advocacy as a purely legal function, it might go a long way to advance access to natural justice safeguards for persons who do not wish hospitalization and/or

treatment. However, such a narrow definition could deny service to those voluntarily hospitalized whose concerns are in areas such as treatment and hospital conditions.

We have grouped patients' rights, therefore, into three main categories:

Self Determination or Legal Advocacy Issues

These include:

- informed consent,
- access to clinical records,
- patient rights information
- review of committal,
- access to legal services,
- incompetency determinations,
- compulsory treatment,
- restraint.

An example of legal advocacy follows:

A 36 year old, diagnosed as suffering from substance abuse and suicidal, was transferred on a first certificate of renewal (Form 4) from a primary facility. Shortly after his admission, when interviewed by the Patient Advocate, he was very angry at being kept in hospital and wanted to know how he could get out. The Advocate informed him generally about his involuntary status and explained that the certificate could be removed by the attending physician if he felt it was appropriate to do so, or the patient could apply to have his certification reviewed by the Regional Review Board. The Advocate explained the review board process to the patient, answered his questions and gave him the date for the next scheduled hearing.

On the next day the patient advised the Advocate that he was going to wait and see if the doctor would allow the certificate to expire (5 days

later). If the certification was renewed he indicated he would apply for a hearing next month.

The certificate was renewed. The client asked the Advocate to assist him to complete the application and to contact a lawyer on his behalf. He designated three lawyers, in order, to be contacted to represent him. His first choice lawyer was available and arrangements were made for the lawyer to interview the patient before the board. The Advocate saw the client briefly after his hearing - he indicated he felt the hearing had gone well and he was pleased with the legal representation of his case.

Three days later the Advocate met the client carrying a suitcase. He had been decertified by the Board and sought discharge the same day. The Advocate made sure he had the phone number for the discharge extension worker in his community and encouraged him to call if he needed any help getting settled.

Quality of Care or Therapeutic Advocacy Issues

These include:

- therapeutic alternatives,
- second opinions
- choice of primary treatment

- staff,
- clinical safeguards,
- information about treatment/
frequency of access to
physicians,
- discharge plans,
- adequate supervision.

An example of therapeutic advocacy follows:

A 48 year old woman was admitted to hospital. About one month after her admission, the timing of her medication was adjusted and as a result the patient refused to consent to treatment.

Initially the patient had been taking lithium tablets 4 times a day and lorazepam at bedtime. She also received a haldol injection every two weeks and cogentin as required. She discontinued medication when it was adjusted to 3 lithium tablets in the evening and one in the morning. She told her doctor she wanted to take lithium 4 times a day as she had before.

The Patient Advocate met with the client's doctor. On being instructed by the client, the Patient Advocate asked that the doctor explain why the heavy bedtime dosage had been prescribed.

The doctor insisted that the patient already knew what her medication was for and was "manipulating and playing games". The physician stated clearly that it was the doctor's decision alone that would decide what treatment a patient should receive.

The Patient Advocate clarified that the patient was not refusing the specific medication ordered but only wished the timing to be changed. Nevertheless the doctor refused to make any adjustments.

On the client's instructions the advocate discussed the problem with the patient's nurse. The evening nurse was quite willing to sit with the patient to discuss the issue at length. The next day this case was brought to the treatment team where it was decided that our client's medication would be adjusted according to her wishes.

This is an example where the Patient Advocate successfully negotiated changes within the system, sometimes with the support of the treatment team.

Undertaking therapeutic advocacy has been difficult. Advocates always have to be clear when speaking to treatment staff that they are acting on clients instructions - voicing the

concerns of the patient. Too often Advocates involvement in therapeutic advocacy has been viewed as anti-therapeutic - interfering with the patient/physician relationship and with the physician's judgement to treat and heal.

However, this particular advocacy role is slowly becoming recognized. It is important that the Psychiatric Patient Advocate Office continue to assist patients in obtaining the type and quality of treatment they wish.

Quality of Life or Social Advocacy Issues

These include:

- privileges,
- economic status,
- privacy and confidentiality,
- security for patients and their property,
- recognition of individuality,
- access to religious services,
- contact with family and friends,
- services in the patient's first language.

Two examples of social advocacy follow:

This case involved an application for unemployment insurance of an

informal patient hospitalized for severe depression. The client had accrued a sufficient number of weeks of employment to potentially qualify for unemployment benefits—but not sick benefits—under the Unemployment Insurance Act.

During the appeal process the Advocate assisted the client by negotiating directly with the Employment Canada Office.

His efforts succeeded in obtaining agreement from Employment Canada that benefits would be made available to the client if his psychiatrist felt he was "ready, willing, and able to work".

The client's psychiatrist agreed that gainful employment would be therapeutically positive, while also recommending continuation of his hospitalization. Upon the Advocate's request, the psychiatrist wrote to Employment Canada indicating that the client was ready and able to work. Thus the client's benefit application was allowed.

The objective benefit of this case was twofold: First, it established a precedent whereby Unemployment Insurance benefits may be collected by an in-patient of the Psychiatric Hospital. Secondly, the case provided an opportunity for an Advocate and a

psychiatrist to work together, thus easing some of the tension the Advocate's role may sometimes cause.

A 40 year old with a long history of manic depressive illness had been fired from her job and her application for disability pension under the Canada Pension Act had been disallowed. The physician requested that the Patient Advocate see this patient and assist her to appeal the decision.

Meetings with the vocational worker revealed that the client was let go from her job because she was functioning at progressively lower levels until her employer could no longer keep her on. This woman has a very limited intellectual capacity and no job skills.

The physician reported that while her illness is fairly well controlled with medication, she is not able to cope with stress or change — which precipitated her admissions to hospital.

Her financial distress, related to the loss of her job, was a major factor in her hospitalization and would necessitate prolonged or repeated hospitalization. The doctor believed that the woman was not able to pursue new employment nor likely to be

employable in the foreseeable future.

In consultation with the vocational worker, the physician, and the patient, a medical report, a vocational assessment, and a letter from the Advocate was sent to the Canada Pension Board asking for a review of the decision denying the pension.

The Advocate argued that persons disabled due to mental illness should be given the same access to pension rights as those disabled for physical reasons. It was also asserted that granting a pension would enable the patient to receive treatment for her illness in the least restrictive environment, her home.

Five weeks later the case had been reviewed and the patient had been granted disability status.

Social Advocacy, in these two cases, relied on specific statutes as well as on the willingness of a government official or tribunal to be convinced that inequities would continue without a new application of those laws.

In many cases, there is a rule, procedure, or hospital guideline which is inequitable and which negatively affects our clients. Then, successful advocacy depends upon the ability of the Advocate to negotiate individual

cases or to convince the Administrator of the need for systemic change. The Administrator may be constrained by staffing and budgetary restrictions which prohibit a solution in the client's favour.

But in many other cases, a fair hearing of the complaint and a consideration of the particular rule, procedure or guideline, by the appropriate staff, could result in a satisfactory resolution.

PROGRAM ACTIVITY - STATISTICAL REVIEW

The Patient Advocate Program is eleven months old. We began opening client files on May 17, 1983. At the end of the fiscal year, March 31, 1983, we conducted a demographic study of our clients. This data was compared with Ministry of Health statistics derived for a census of all Psychiatric Hospitals taken on March 31, 1983, and from hospital admission data for the fiscal year April 1, 1982 to March 31, 1983.

During this study period, 2,223 files were opened representing about 3.5 concerns per file.

The study showed

- two thirds of our clients were males, a number comparable to the population of hospital admissions over the same period;
- our clients were among the younger patients, that is under

age 45;

- our clients, as expected, came largely from the involuntary population in hospital, however, we did not attract a disproportionately high number of criminally committed persons as might have been expected.
- persons with organic and senile psychoses (represented in the geriatric population) were significantly underrepresented among our clients.

During our first year, Advocates reached out to patients, staff, families and friends of clients:

- 68 per cent of our clients were self referred;
- 15 per cent were referred by hospital staff;

- only 9 per cent were reached through Advocates' proactivity;
- 8 per cent were referred by other patients, family, friends.

Issues raised by our clients comprised a total of 68 different topics which we grouped into three categories, legal, therapeutic and social.

The most common hospital-related issues were legal in nature. For instance, patients requested information and/or action on legal rights more than 40 per cent of the time.

Therapeutic issues and, in particular, the planning for discharge and treatment, accounted for 21 per cent of all in-hospital issues.

Advocates were able to conclude issues pertaining to the Regional Review Board more frequently than in any other major area. These issues were primarily applications by patients for reviews of their Certificates of Involuntary Commitment.

Files are closed by Advocates when the case is completed whether or not the client is satisfied. Files are also closed after 30 days if there is no further client contact or upon discharge or death.

Of all files closed:

- 49 per cent concluded to the client's complete or partial satisfaction either by negotiation or referral;
- 15 per cent failed to win client satisfaction;
- 11 per cent were abandoned by the client;
- 25 per cent were files where information and education only was provided.

Therapeutic issues were more likely to be resolved satisfactorily by negotiation. However, they were also more frequently abandoned. Legal issues usually resulted in referral, commonly to Regional Review Boards or outside legal counsel. Social issues had a reasonably high level of successfully negotiated resolutions.

Data upon which these conclusions were drawn can be found in the tables on pages 15-23 of this Report.

The initial objectives of the program were realized by demonstrated success in terms of client satisfaction and in terms of the Advocates' reliance on non-confrontational remedies.

TABLE 1

Total Client Files Opened by Patient Advocates in Ten Ontario Psychiatric Facilities from May 17, 1983 to March 31, 1984 Examined by Sex, Compared to Ministry of Health Mental Health Standard Tables by Sex, by Admissions to these Facilities from April 1, 1982 to March 31, 1983 and by Sex, by Census Data March 31, 1983

Sex	Ministry of Health Data					
	Total Client Files		by Admissions		by Census	
	N	%	N	%	N	%
Males	1425	64	7925	62	2787	62
Females	798	36	4838	38	1740	38
TOTAL	2223	100	12,763	100	4527	100

TABLE 2
Total Client Files Opened by Patient Advocates from May 17, 1983 to March 31, 1984 by
Seven Age Categories Expressed as Total Number and Percentage Compared to
Ministry of Health, Mental Health Standard Tables by Admission Data from April 1, 1982 to
March 31, 1983 and by Census Data for March 31, 1983

Age Categories	Ministry of Health Data					
	Total Client Files		by Admissions		by Census	
	N	%	N	%	N	%
0-14	--	--	63	0.4	13	0.3
15-24	427	19	2704	21	644	14
25-34	781	35	3581	28	959	21
35-44	430	19	2341	18	716	16
45-54	285	13	1589	12	574	13
55-64	151	7	1303	10	628	14
65 +	107	5	1201	9	993	22
Not Recorded	42	2	--	--	--	--
TOTAL	2223		12,763		4527	

TABLE 3

Total Client Files Opened by Patient Advocates from May 17, 1983 to March 31, 1984 by Type of Status Compared to Ministry of Health, Mental Health Standard Tables by Census Data on March 31, 1983, Expressed as Total Number and Percentage

Status	Total Client Files by Patient Advocates		Ministry of Health by Census Data	
	N	%	N	%
Total Informal	595	27	2657	59
Total Involuntary	1405	63	1870	41
Total Not Recorded	110	5	--	--
Total Outpatients	113	5	--	--
TOTAL	2223		4527	

TABLE 4

Total Client Files Opened by Patient Advocates in Ten Ontario Psychiatric Facilities from
May 17, 1983 to March 31, 1984, by Source of Referral to Advocates

Referral Source	N	%
Individual Referral Sources:		
Self	1515	68
Family	39	2
Friend	11	1
Other patient	39	2
Other client	4	0
Nursing staff (N1, N2, N3, RNA)	181	8
Physician	45	2
Psychologist	3	0
Social worker	41	2
Grouped referral Sources:		
Program-related	207	9
Other Clinical Staff	15	1
Non-clinical Staff	32	2
Administration	8	0
Regional Review Board	9	0
Lieutenant-Governor's Advisory Review Board	0	0
Other external individuals or agencies	74	3
TOTAL	2223	100

TABLE 5

Client Files Opened by Patient Advocates in Ten Ontario Psychiatric Facilities from May 17, 1983 to March 31, 1984, Showing How 1515 Clients Who Were Self-Referred Learned of the Program

Sources whereby self-referring clients learned of the patient advocate office	N	%
Individual Sources:		
Self (infers a repeat client)	48	3
Family	14	1
Friend	0	0
Other patient	120	8
Other client	214	14
Nursing staff	84	6
Physician	22	2
Psychologist	2	0
Social worker	12	1
Grouped Sources:		
Program-related	903	62
Other Clinical Staff	1	0
Non-clinical Staff	16	0
Administration	1	0
Regional Review Board	17	1
Lieutenant-Governor's Advisory Review Board	0	0
Other external individuals or agencies	34	2
TOTAL	1515	100

TABLE 6

A Total of Sixty-Eight Issues which Form the Source of All of the Issues Dealt with by Patient Advocates Broken Down Into Four Major Categories of Therapeutic, Legal, Social and Other and by Whether the Source of the Issue was Internal or External to the Hospital

Therapeutic Issues	Legal Issues	Social Issues	Other Issues
<u>In-Hospital</u> Admission Discharge Communication--Client with M.D. Communication--Client with Nursing Staff Treatment Plan--General Treatment Plan--Medication Treatment Plan--Behaviour Modification Treatment Plan--ECT Treatment Plan--MAP Treatment--Outside Second Option Restraints--Mechanical Restraints--Chemical Seclusion Industrial Therapy, Occupational Therapy and Vocational Therapy Client wants change of staff	<u>In-Hospital</u> Commitment Regional Review Board Lieutenant-Governor's Warrant--Terms Advisory Review Board Client wants Information from file Lawyer--Access to file Get Legal Assistance for In-Hospital Issues Treatment--Informed consent Treatment--Substitute consent Legal Aid Matrimonial Litigation	<u>In-Hospital</u> Finances--In-Hospital Privileges--General Privileges--Phone Privileges--Correspondence Privileges--Tobacco Privileges--Clothes Privileges--Other Personal Property Lost/Damaged Housing Placement Other Patient Recreational Activities Food	<u>In-Hospital</u> General Program Information Client Wants Information from staff Seeks Information on Legal Rights--Criminal Seeks Information on Legal Rights--Landlord/Tenant Seeks Information on Legal Rights--Mental Health Law Seeks Information on Legal Rights--Other Transfer within Hospital Transfer Inter-Hospital Denial of release of Information to Patient Advocate Other In-hospital Issue
	<u>Out-of-Hospital</u> Get Legal Assistance for Out-of-Hospital Issue Legal Aid Obtain Licenses or other Documents Matrimonial Litigation Child Welfare Litigation Criminal Matter Conditions of Probation	<u>Out-of-Hospital</u> Family Education Finances--Conduct of Public Trustee Finances--Welfare Finances--Family Benefits Finances--Out-of-Hospital Finances--Other	<u>Out-of-Hospital</u> Other outside Issue

TABLE 7

Total Concluded Issues for January, February, and March 1984, undertaken by Patient Advocates in Nine Ontario Psychiatric Facilities described by Outcomes according to Degree of Client Satisfaction, Complete, Partial, None, Abandoned and Other, by the Issues Categories, of Therapeutic, Legal, Social and Other, and sub-categorized by Type of Action taken, Negotiation or Referral, by Number

Issue Category	Therapeutic		Legal		Social		Other		Total	
Action Taken	Negotiation	Referral	Negotiation	Referral	Negotiation	Referral	Negotiation	Referral	Negotiation	Referral
Outcome	N	N	N	N	N	N	N	N	N	N
Complete Satisfaction	103	10	195	39	134	4	76	2	508	55
Partial Satisfaction	23	0	16	25	46	4	16	0	101	29
Not Satisfied	32	1	76	35	43	0	16	4	167	40
Abandoned	33	4	38	21	30	3	23	1	124	29
Other	11	37	24	115	17	85	10	57	62	294
TOTAL	202	52	349	235	270	96	141	64	962	447
	254		584		366		205		1409	

TABLE 8
TRENDS IN PSYCHIATRIC INPATIENT POPULATION

Year	Admissions	Total Under Care During Period	Discharges	Deaths	On the Books Ends of Period	Average Daily Population In Hospital
Psychiatric Hospitals (1)						
1978/79	13,316	18,247	13,287	289	4,357	3,953
1979/80	12,612	17,247	12,383	266	4,330	3,840
1980/81	12,665	17,397	12,231	259	4,508	3,850
1981/82	11,595	17,675	12,285	298	4,514	3,919
Psychiatric Units of General Hospitals						
1978/79	34,870	36,774	34,528	8	1,814	1,659
1979/80	35,496	36,424	34,562	27	1,851	1,823
1980/81	35,376	37,482	34,480	34	1,950	1,782
1981/82	34,123	36,099	33,332	28	1,760	1,771

TABLE 9
Residents in the Homes for Special Care Program: 1965-83

	Year	Number of Occupied Beds	Number of Homes
Nursing Homes	1965	1,621	
	1970	5,651	
	1981	4,664	
	1983 (July)	4,364	261
Residential Homes	1965	47	
	1970	1,502	
	1981	2,078	
	1983 (July)	2,170	297

NOTE: Includes both ex-provincial psychiatric hospital patients and developmentally disabled residents

PSYCHIATRIC PATIENT ADVOCATE OFFICE

FINANCIAL STATEMENT

1 April 1983 - 31 March 1984

Salaries, wages and benefits	\$532,712
All other operating costs	\$ 78,791
TOTAL	\$611,503